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Nova Southeastern University

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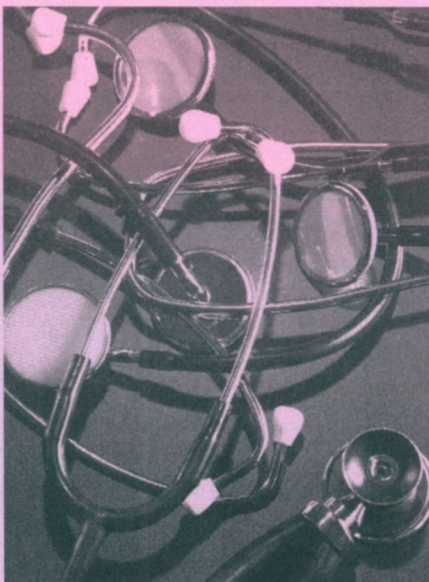


## The VA Medical Centers and Ties to Graduate Medical Education

A September 2005 report of a Department of Veterans Affairs (VA) Advisory Committee strongly reaffirmed the value of the VA's commitment to resident medical education, including its value to the quality of care received by veterans. Today, 107 of the 125 allopathic medical schools have formal affiliation agreements with VA medical centers 60 years after such partnerships were included as policy by the Department of Veterans Affairs. In addition, 70 percent of VA physicians hold faculty appointments at an affiliated medical school, facilitating teaching and research opportunities for them.

The Department of Veterans Affairs is the single largest provider of graduate medical education (GME) and funds nine percent of all residency positions. In fact, about a third of all residents in the United States receive at least some of their training at a VAMC. The Department of Veterans Affairs Advisory Committee was chaired by Timothy Flynn, M.D., who serves as associate dean for GME at the University of Florida. The report concludes that the VA can exert

leadership in enhancing GME effectiveness as it has in patient safety with the implementation of electronic medical records. While the total percent of VA-funded residencies has been reduced from 11 to 9 percent, the number of positions has not changed, but rather the number of non-VA funded GME positions has increased. However, the committee recommended that the 11 percent level should become the VA's goal, requiring an increase of approximately 2,400 residency positions.



The committee realizes that current fiscal pressures make the date when this can happen uncertain. The committee advised the VA that there was a need to support new and emerging specialties because of their importance to the care of veterans. It suggested using new VA care sites to shift primary care training to ambulatory venues. In addition, it emphasized the importance of having an adequate educational infrastructure and appropriate patient census to support new GME affiliations. Also noteworthy was the recommendation that allocated new positions should be in areas of need rather than reallocating positions from currently functioning programs.

(Cohen J. "A Word from the President: Strengthening Ties that Bind? Our GME partnership with the VA." AAMC Reporter. November 2005.)

## "Medical Education Highlights for Primary Health Care"



## Tulane University Medical School Recovery from Katrina

As a result of Hurricane Katrina, Tulane University is addressing a major financial challenge that includes \$200 million in recovery costs compounded by a major budget shortfall next year. The medical school will reopen in the fall of 2006 with major reductions in the faculty as well as class size. Its renewal plan calls for the elimination of 180 faculty positions to a total of 345 as a result of the decreased population of New Orleans and changing health care needs in the city.

Tulane President Scott Cowen, while regretting the faculty reductions, said they were necessary to secure the future of the university. The plan for the School of Medicine is to focus added emphasis on its research programs, many of which are NIH-funded. It was developed by a blue-ribbon panel of internal and external advisors and experts including the Board of Trustees, the President's Faculty Advisory Committee, and top administrators from several of the nation's major academic institutions.

(Tulane University Release. "Tulane University Announces Bold Renewal Plan." December 8, 2005, and New York Times, January 12, 2006.)



## Infectious Disease Fellow and a U.S. Veteran Amputee of Operation Iraq

Emil Lesho, D.O., a Walter Reed Army Hospital infectious disease fellow, describes his emotional experience washing the remaining hand of a young victim of the Iraqi conflict. He vividly describes washing each web space, each finger, the veteran's palm—a seemingly simple set of tasks. However, they caused great apprehension to this fellow who had been used to seeing patients who were elderly amputees with diabetes and peripheral vascular disease. He then described how he fumbled to further assist the young amputee tie his shoelace, including his slowness accomplishing this and his discomfort in the encounter.

This young physician admitted how unhinged he was by the veteran's request to have this assistance provided. The fellow freely described that in spite of seeing many amputees, sometimes such an

unexpected and unique response is experienced. Medical schools, he suggests, should expose students to washing and dressing patients as part of their curricula. Such skills, he remarks, are not as simple or inconsequential as they may seem. He believes that through additional training like this, future physicians will become more comfortable with this level of physical connection.

(Lesthos E. "Teaching and Learning Moments: Hand in Hand." *Academic Medicine*. 81:1 (56); 2006.)

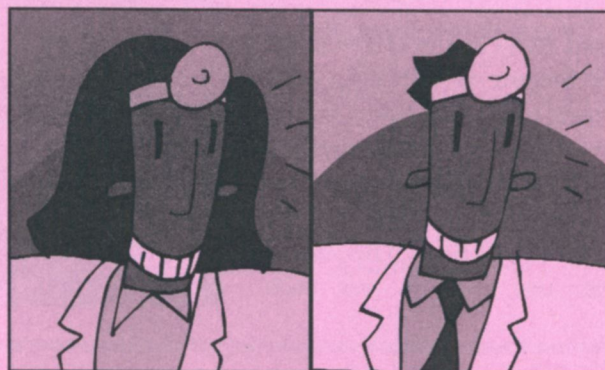
## Predictive Value of Medical School Admissions Interviews



While grade-point averages achieved in undergraduate school and Medical College Admissions Test scores may predict the ability to handle the academic challenges of medical school, they do not adequately assess the human qualities of applicants. These non-cognitive factors differentiate one medical school applicant from the other. Non-cognitive factors include such things as listening skills,

conscientiousness, empathy, and the ability to relate to patients. Letters of recommendation and interviews have not been reliable or valid in assessing these non-cognitive abilities, probably due to the bias nature of the process.

In attempt to rectify this, a structured interview was developed at the University of Iowa School of Medicine with current medical students posing as applicants. Examples of questions included, "Thinking back over the past few years, what is one experience you have had that influenced or changed your life in a significant way?" and "The practice of medicine is changing rapidly and, as a physician, you will be involved in this evolution. How do you see those changes affecting your role in the practice of medicine?"





In addition, a 21-item questionnaire assessed non-cognitive traits. Scales included *Synthesis/Integration* (ability to think quickly), *Interpersonal Skills* (interaction with others), *Concern* (measure of altruism and interest in the well being of others) and *Professionalism* (acting with confidence and recognizing personal limitations.)

The intent of the research was to distinguish among medical student non-cognitive performance. However, while the results of this effort were promising, they were not strong enough to suggest all medical schools employ them. They suggested that performance-based measures such as simulated patients and structured behavioral interviews may capture non-cognitive abilities essential to medical practice.

(Streyffler L. Altmaier EM, Kuperman S, and Patrick LE. "Development of a Medical School Admissions Interview Phase 2: Predictive Validity of Cognitive and Non-Cognitive Attributes." *Medical Education Online*. 10:14; 2005. <http://www.med-ed-online.org>.)

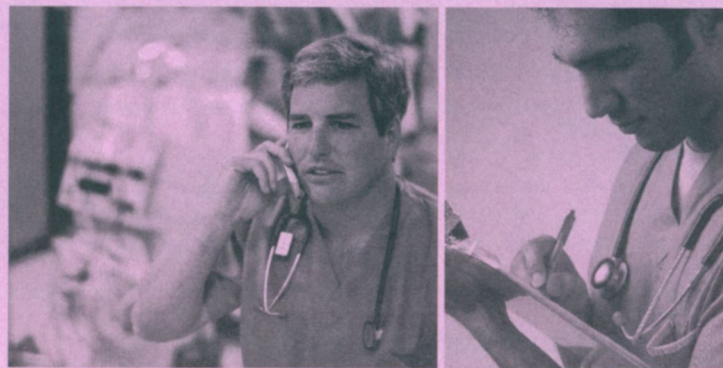
## Foreign Doctors in the U.S. from the Developing World

A *New England Journal of Medicine* article published in October 2005 reported that 25 percent of U.S. physicians are foreign medical school graduates. A physician/medical educator believes that America should not resolve its physician shortage by "stealing" doctors from countries that need them desperately. He indicates that since 1980, the number of graduates from U.S. medical schools has not changed even though the population has increased by 50 million people and that the aging baby-boomer generation will exacerbate this significantly. As a result, this will create a greater demand for physicians from the Caribbean, Asia, and Africa. He believes that U.S. medical schools have limited their enrollment because of elitism, creating an inadequate number of "rank-and-file general practitioners." He further recommends that not all medical schools need to be world-class academic research centers.

In addition, he applauds the endorsement of the American Council on Graduate Medical Education that recommended medical schools increase their enrollment by 15 percent. Another recommendation is that the United States invests in training physicians and building hospitals overseas (e.g., Asia and Africa) to facilitate them keeping their medical graduates at home. The World Health Organization, with American assistance, should augment the low salaries of physicians in developing nations. The current move toward globalization is bringing foreign doctors here, which he feels enhances the potential spread of viral-borne diseases like avian flu, and is partially enhancing the scarcity of physicians in these nations.

(Wall MM. "Stealing from the Poor to Care for the Rich." *Op-Ed. New York Times*. December 14, 2005.)

## Effect on Surgical Faculty of Reduced Worked Hours



The effect of reduction in work hours has been assessed for residents but not on faculty. A study of nine general surgical programs in the United States that included 233 faculty members in eight states in three time zones was performed. This included five academic and three community hospital programs. A survey requested responses to such questions as the expectations and standards for residents, whether supervision by faculty improved, the degree to which faculty time to teach residents was decreased, how much additional time faculty members were on call, and the increased number of times faculty members were called back to the hospital. It also included the degree that time by faculty members was decreased to enhance their surgical skills, their increased workload at the hospital, requirements that they perform duties previously handled by residents, increases in stress, and decreased satisfaction with their academic position.



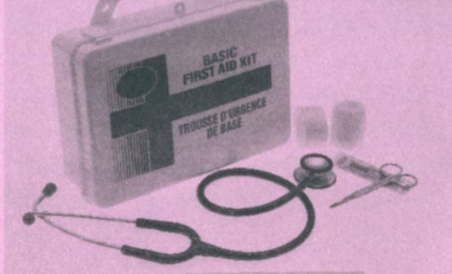
Faculty members who responded to the questionnaire and those interviewed believed that the reduction in the duty hours of surgical residents was associated with lowered faculty expectations and lowered standards for residents. They also believed there was a loss of teaching time, increased faculty work and stress, as well as less satisfaction by faculty. The study's overall conclusion was that the reduction in the work hours of residents had significant consequences on surgical faculty. In addition, they felt that future



studies of the effect of the reduction of hours for surgical residents should not overlook the faculty. It appeared that the faculty responses did not vary by program type. Some believed that reduced resident hours also would result in a long-term decline in the research activities of faculty. There also was a perception that some residents used the new rules to reduce their involvement in the programs.

(Coverdill JE, et al. "Duty-Hour Restrictions and the Work of Surgical Faculty: Results of a Multi-Institutional Study." *Academic Medicine*. 81:(50-56); 2006.)

### Patient Safety Curriculum for Second-Year Medical Students



There is no mandate for those in the health professions to complete any patient safety course as a continuing education requirement for license renewal. Among the reasons is a fear of tort action as well as the worry that such errors would be reported to licensing boards. This contributes as a barrier to role-modeling behaviors of reporting, investigating systems failures, and disclosing errors to patients, which further slows progress toward patient safety initiatives. Evidence does exist, however, that those health care systems that do adopt full-disclosure policies and practices can reduce their liability.

At the University of Missouri-Columbia, second-year medical students receive a course in patient safety and medical fallibility. In

this curriculum, they participate in a program designed to acquire knowledge, skills, and attitudes relevant to patient safety and related issues. The curriculum includes an overview on the epidemiology of patient safety, including the recommendations from the Institute of Medicine report titled "To Err is Human." This is followed by discussions on error reporting, health systems that may lead to error, tools that may improve safety, and finally, the ethical obligations surrounding patient safety, including student role-playing in disclosing errors to patients (only at the direction of an attending physician).

While the curriculum can affect the knowledge, skills, and attitudes of students regarding patient safety that is sustained one year later, it was concluded that these efforts be addressed in their clinical education in order to achieve lasting results.

(Madigosky WS, et al. "Changing and Sustaining Medical Students' Knowledge, Skills, and Attitudes About Patient Safety and Medical Fallibility. *Academic Medicine*. 81:(94-101); 2006.)



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